CITY OF MINNEAPOLIS - HEALTH PLAN ENROLLMENT/CHANGE FORM

For changes not available through HRIS Employee Self Service due to documentation requirements.

Employee Name _____ Employee Payroll ID # _____ Effective Date _____

Home Phone _____ Work Phone _____

Enrollment/Change Reason: Check one and see requirements below.

_____ **Waive or change coverage due to enrollment in another group plan.**

_____ **Enroll in City plans due to loss of group coverage under another plan.**

_____ **Enroll dependent(s) newly eligible due to birth, adoption, legal custody, marriage, loss of other coverage, etc.**

_____ **Remove dependent(s) no longer eligible due to marriage, divorce, etc. (provide explanation below).**

- If change is due to a gain or loss of coverage under a non-City group plan, attach a copy of proof of 'other' coverage or LOSS of coverage showing the date coverage either went into effect or was cancelled.
- To add a dependent, you must provide copies of marriage and/or birth certificate or court documents related to placement/adoption or custody. To add a grandchild you must provide a copy of a federal tax return listing the child as a dependent and a copy of current report card, school registration, doctor's bill, or day care statement showing your current address.
- If change is due to divorce, you must provide a copy of your divorce decree - first page, last page, other page(s) referring to health insurance.

CURRENT MEDICAL COVERAGE:

_____ WAIVE _____ Single _____ Family

_____ Medica Elect (Standard or Wellness)

_____ Medica Essential (Standard or Wellness)

_____ Medica Choice (Standard or Wellness)

CHANGE MEDICAL COVERAGE TO:

_____ WAIVE _____ Single _____ Family

Complete only if enrolling mid-year

_____ Medica Elect (Standard or Wellness)

_____ Medica Essential (Standard or Wellness)

_____ Medica Choice (Standard or Wellness)

CURRENT DENTAL COVERAGE:

_____ Single _____ Family

CHANGE DENTAL COVERAGE TO:

_____ Single _____ Family

FLEXIBLE SPENDING ACCOUNTS:

_____ Decrease _____ Increase (or enroll) Annual Health Care Flexible Spending $ _____ New Annual Amount

_____ Decrease _____ Increase (or enroll) Annual Dependent Care Spending $ _____ New Annual Amount

DEPENDENTS: Complete the information in the chart below.

NAME	SEX	RELATION-SHIP	SSN -Required by Federal law for Spouse	DATE OF BIRTH	MEDICAL		DENTAL		*PRIMARY CLINIC NUMBER** ***(11 digits)***
					Enroll	Delete	Enroll	Delete	
		SPOUSE							

* ***Primary care clinic elections for Elect and Essential networks:*** All family members must choose a primary care clinic within either the Elect network or the Essential network. You cannot split family members between the two networks. If you elect Medica Elect or Medica Essential, you must enter the 11-digit clinic number in the space provided. Visit the CityTalk website at http://citytalk/benefits/medical insurance to find network providers.

DELETING DEPENDENTS: Print name / address of deleted dependent(s) and explanation for removing dependent(s)

_____

_____

_____

As an employee, eligible to participate in the City of Minneapolis Medical Plan, I hereby authorize the City of Minneapolis to deduct required pre-tax premiums for coverages elected above. Further, I understand that if I fail to complete a health care option change on a timely basis that I may not be eligible to apply for medical plan coverage until the next Open Enrollment period.

_____ _____

Employee Signature **Date**

Fax completed form to **612-673-2533** or **mail** your completed form to:

City of Minneapolis, Human Resources-Benefits, Room 100 Public Service Center, 250 S 4th Street, Minneapolis MN 55415-1339

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law.